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ABSTRACT

Previous studies have shown that paradoxical directives are effective in decreasing depression over time but, in general, found that they were no better than nonparadoxical directives. Subjects in the studies were mildly to moderately depressed college students who were not assessed on reactance level. This study examined the differential effects of paradoxical reframing versus paradoxical restraining directives in high- or low-reactant clients (N=67) from a clinical population who experienced moderate to severe depression. High- and low-reactant clients were randomly assigned to one of three treatment conditions: a paradoxical reframing directive condition, a paradoxical restraining directive condition, or a pseudo-therapy control group. Treatment involved five sessions with a counselor. A follow-up session occurred approximately 4 to 6 weeks after treatment ended. Results showed that subjects in all conditions significantly reduced their depression. There were no differential effects due to treatment condition or reactance level. Subjects in the control condition felt significantly more in control of their depression at follow-up than did subjects in the two paradoxical interventions. All subjects felt significantly better able to cope with their depression at follow-up. Findings have implications for the compliance-defiance model. (Author)

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Reframing and Restraining Directives in the Treatment of Clinical Depression

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Abstract

This study examined the differential effects of paradoxical reframing versus paradoxical restraining directives in high- or low-reactant clients who experienced moderate to severe depression. Previous studies have shown that paradoxical directives are effective in decreasing depression over time but, in general, found that they were no better than nonparadoxical directives. However, subjects used in previous research were mildly to moderately depressed college students. In addition, subjects were not assessed on reactance level. This study utilized moderately to severely depressed clients from a clinical population to test hypotheses concerning differential effects of paradoxical directives. High- and low-reactant clients were randomly assigned to one of three treatment conditions, a paradoxical reframing directive condition, a paradoxical restraining directive condition, or a pseudo-therapy control group. Treatment involved five sessions with a counselor. A follow-up sessions occurred approximately four to six weeks after treatment stopped. Results showed that subjects in all conditions sifnificantly reduced their depression. There were no differential effects due to treatment condition or reactance level. Subjects in the pseudo-therapy control condition felt significantly more in control of their depression at follow-up than did subjects in the two paradoxical interventions condition. All subjects felt significantly better able to cope with their depression at follow-up. Implications of the results for the compliance-defiance model are discussed.

Reframing and Restraining Directives in the Treatment of Clinical Depression

Paradoxical interventions as change-producing techniques have only recently been investigated experimentally. Although such interventions have existed for hundreds of years, only with the work of Alfred Adler and Viktor Frankl were paradoxical interventions applied to human psychological change (Mozdierz, Macchitelli, & Liesiecki, 1976). Paradoxical interventions have been reported to be successful in the treatment of phobias, obsessive-compulsive disorders, and sexual disorders. Recently, paradox has been used to overcome procrastination, anxiety, and depression.

Past research has largely focused on the efficacy of specific paradoxical strategies such as symptom prescription and reframing (Dowd & Milne, 1986). Symptom prescription involves instructing the client to continue to perform the undesired behavior or to perform it on schedule. Reframing, according to Watzlawick, Weakland, and Fisch (1974),

> . . . means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place in another frame which fits the 'facts' of the . . . situation equally well or even better and thereby change its entire meaning. (p. 95)

Several studies (Beck & Strong, 1982; Conoley & Garber, 1985; Feldman, Strong, & Danser, 1982; Kraft, Claiborn, & Dowd, 1985) have shown reframing techniques to be effective in reducing depression in mildly to moderately depressed subjects and to be more effective than symptom prescription. Dowd and Milne (1986), in a review of the literature, concluded that reframing strategies may

be the treatment of choice in dealing with moderate depression.

Another paradoxical technique is restraining, whereby the therapist instructs the client to inhibit change or to cease attempts to change the symptom altogether, thus giving the message that "in order to change, stay the same or give up" (Weeks & L'Abate, 1982, p. 126). While symptom prescription and reframing have been scientifically investigated in a number of studies with a wide variety of problems, restraining strategies, until recently, have not been investigated scientifically. Dowd, Hughes, Brockbank, and Halpain (in press) recently assessed the differential effects of restraining and nonrestraining counselor interventions in the treatment of anxiety and procrastination. Results indicated that restraining and nonrestraining strategies were equally effective in overcoming both problems and were more effective than no treatment. These results replicated those of most previous investigations of the effects of paradoxical interventions in demonstrating comparable efficacy with nonparadoxical techniques.

Another variable of theoretical importance in the effectiveness of paradoxical interventions is psychological reactance (Brehm & Brehm, 1981) which is the motivational force to restore lost freedoms by defying directives. High reactant clients are clinically experienced as oppositional. Rohrbaugh, Tennen, Press, and White (1981) have used the theory of psychological reactance to divide paradoxical interventions into defiance-based and compliance-based strategies. Restraining strategies are defiance-based and are theoretically called for when reactance potential is high while reframing is compliance-based and is most useful when reactance potential is low. Symptom prescription is useful for both high- and low-reactant clients.

While paradoxical theory predicts that defiance-based interventions are most useful when reactance potential is high and that compliance-based interventions are most useful when reactance potential is low, recent research has cast doubt on the utility of the defiance-compliance model. Dowd et al. (in press) found defiance-based and compliance-based strategies equally effective regardless of client level of reactance. However, they did find that level of client reactance was significantly related to improvement in both procrastination and anxiety; in general, low-reactant clients improved most. Different techniques were not differentially effective, however.

There are several possible reasons for these disappointing results. First, the number of studies testing the compliance-defiance model has been small and it could be argued that an adequate test of the model has yet to occur. Second, lack of support for the model may be due to the types of populations used in the studies. Strong (1984), in reviewing experimental studies of paradoxical interventions, noted that in the 12 studies reviewed, subjects were generally clients receiving treatment in outpatient settings, obtained from advertisements in daily newspapers, or recruited from introductory psychology classes. From these data all subjects, except for those used by Ascher (1981), were college students. It could be argued that students represent an atypical population--their problems are usually not severe and not chronic, thus calling into question the generalizability of the research findings in mildly depressed students to clinically depressed clients. Case studies, on the other hand, have largely dealt with clinical subjects. Expansion of experimental research on paradox to clinical populations may provide a more stringent test of the compliance-defiance model.

A third concern regarding research on paradox is that no studies, other than the Dowd et al. (in press) investigations, have sought to assess the effects of client reactance on the effectiveness of paradoxical interventions. Many case studies have demonstrated striking effects in individual clients due to paradoxical interventions only after more conventional treatments have failed; these subjects may well have been highly reactant.

A fourth concern relates to the use of self-report measures. Previous studies have used self-report measures such as the BDI, to differentiate between depressed and nondepressed groups. As such, this is an inappropriate use of the instrument and therefore claims that depressed college students are qualitatively related to but quantitatively less severe than primary depressions are to date unsupported (Depue & Monroe, 1978).

The first purpose of this study was to compare the therapeutic effects on depression of a compliance-based paradoxical directive (reframing), a defiance-based directive (restraining), and a pseudo-therapy control group (Wilkins, 1985). A clinical population was used in this study in order to overcome the limitations of previous studies on paradox and depression, i.e., minimal severity of dysfunction and use of nonclinical populations. The occurrence of depressive symptomatology was the dependent variable since previous studies on depression have shown it to be amenable to change via paradoxical strategies, particularly reframing (Kraft et al., 1985; Strong, 1984). A second purpose of the study was to assess the mediating effects of psychological reactance on the utility of different paradoxical strategies.

The following hypotheses were tested: (1) Subjects in the two treatment conditions will show a greater reduction in depressive symptoms over time than

will those in the pseudo-treatment control group. (2) Compliance-based strategies (reframing) will be more effective in reducing depressive symptoms over time than will defiance-based strategies (restraining) regardless of the level of reactance. Previous studies have shown that reframing is helpful in overcoming mild to moderate depression (Kraft et al., 1985), while the effectiveness of restraining strategies in the treatment of depression has yet to be determined. (3) Based on the compliance-defiance model regarding specificity of treatment strategy, it was hypothesized that depressed subjects who are low in reactance will decrease their depressive symptoms more than will high-reactant subjects under a reframing condition. Conversely, high reactant subjects under a restraining condition will decrease their symptoms more than those subjects who are low in reactance. Thus, a treatment x level of reactance interaction is predicted. (4) To demonstrate consistency of treatment and counselor effects, it is hypothesized that perception of counselor's attractiveness, expertness, and trustworthiness will not differ significantly across treatment groups or across counselors. (5) Subjects in all treatment conditions will feel significantly more in control and better able to cope with their depression at follow-up, as measured by Questions 1 and 6 of the Attribution Scale. Subjects in the two paradoxical treatment conditions will differ significantly from those in the pseudo-control condition, but will not differ from each other. (6) Low-reactant subjects will feel significantly more in control and better able to cope with their depression in the reframing treatment condition than in the restraining treatment condition. Conversely, high-reactant subjects will feel significantly more in control and better able to cope with their depression in the restraining treatment condition than in the reframing. (7) Low-reactant

subjects will have significantly higher scores on the external dimension of the Attribution Scale (Questions 2, 4, and 5) than high-reactant subjects. Conversely, high-reactant subjects will have significantly higher scores on the internal dimension of the Attributional Scale (Question 3) than low-reactant subjects. (8) Subjects in the restraining treatment condition will be more likely to view changes in depression as internally caused than those in the reframing condition. Conversely, subjects in the reframing treatment will be more likely to view changes in depression as externally caused than those in the restraining treatment condition.

Method

Subjects

A total of 67 subjects were solicited from a clinical population at a community mental health center in the Midwest. Clients who carried a primary or secondary diagnosis of depression were screened for current depressive symptomatology. Staff clinicians rated client symptoms on the Hamilton Rating Scale for Depression (Hamilton, 1960); clients with scores of 22 or more were selected for inclusion in the study.

Measures

Beck Depression Inventory (BDI). The BDI (Beck, 1967) was the dependent measure used to assess change from session to session as well as to measure pretest, posttest, and follow-up differences. The BDI is a self-report measure with reported internal consistency and test-retest reliability of .78 and .88 (J. Beck & Strong, 1982). The person's score represents the number of items endorsed and severity of symptoms. The measure is sensitive to changes in depth of depression over time.

Zung Self-Rating Depression Scale (SDS). Zung (1965) developed this scale to incorporate symptoms of the depressive syndrome into a self-administered scale. Twenty items were selected on the basis of factor analytically derived symptom clusters covering "pervasive affect," "psychological concomitants," and "physiological equivalents or concomitants." This scale was used as a second dependent variable to assess changes in severity of depression at pretest, posttest, and follow-up. Zung (1973) reports split-half reliability of r = .73.

Hamilton Rating Scale for Depression (HRSD). This 17-item scale (Hamilton, 1960) is completed by the clinician to determine the level of severity of depressive symptoms and was used to screen severity of depression for inclusion in the study. While reliability data for this instrument is scarce, it correlates highly (r = .71) with a behavioral rating scale of depression and demonstrates high interrater reliability when used by well-trained raters (Lewinsohn, Bigler, & Zeiss, 1976). Hamilton (1976) reported an initial interrater reliability on the HRSD of .90, but noted that others have reported findings which range from .89 to .98.

Therapeutic Reactance Scale (TRS). This 28-item scale (Dowd, Milne, & Wise, 1984) was used to determine level of client reactance. It measures two factors of behavioral and verbal reactance as well as "Total Reactance." Internal consistence reliability coefficients range from .74 to .84 while test-retest coefficients range from .57 to .60. A median split was used to determine high or low reactance, with a score of 67 or above comprising the high-reactance group and 66 or below comprising the low-reactance group.

Counselor Rating Form-Short Version. This instrument (CRF-S; Corrigan & Schmidt, 1983) consists of 12 bipolar adjectives scored on a seven-point scale

to measure counselors' attractiveness, trustworthiness, and expertness as perceived by the client. This instrument was used as a manipulation check to measure consistency of counselor ratings across counselors as well as across treatment conditions.

Attribution for Change Scale. This instrument was developed by Kraft, Claiborn, and Dowd (1984) to measure clients' attributions for change. Questions 1 and 6 were given at pretest, posttest, and follow-up, while Questions 2, 3, 4, and 5 were given at posttest and at follow-up.

Procedures

Treatments. Three treatment conditions were used. The paradoxical reframing directive, patterned after those of J. Beck and Strong (1982), gave the subject's depressive behavior and/or characteristics a positive connotation. Positive reframing statements such as "being alone and feeling down shows a great tolerance for solitude and basic self-satisfaction"; and "feeling badly about yourself rather than taking grievances out on others shows a willingness to sacrifice for the good of others" were used, as they are similar to those actually used by practitioners who employ paradox.

A paradoxical restraining directive consisted of pointing out the negative consequences of change (e.g., "If your depression lifted, people would react to you more favorably and would put greater demands upon you"; "If you gained control of your life, your depression would lift and you'd feel better, which might be an uncomfortable position to be in."). An inhibiting change strategy was also used, with the counselor instructing the client to go very slowly and cautiously in attempting to change.

A pseudo-therapy control group (Wilkins, 1985) was used to measure the therapeutic effects of the treatment conditions and to control for the effects and quantity of contacts clients received. The subjects met in a group format with a counselor who presented a different theory of depression each week (after Davidson, 1976). Discussion was held regarding the nature of the theory and how it applied to each group member. Discussion and interaction within the group was severely curtailed so as not to approximate a therapeutic group process. Thought that would provide a more realistic comparison to the treatment conditios than a waiting list control group. In addition, there are ethical considerations which preclude the use of a waiting list control group at a mental health center.

Counselors

The counselors (N = 10, six women and four men) were employed at the mental health center at which the study was conducted and included four doctoral candidates in counseling or clinical psychology as well as six master's level practitioners with at least two years experience ($\bar{x}$ = 4.8 years) in working with a clinical population. Eight of the counselors received training in the treatment procedures; each administered both paradoxical treatment conditions. Two counselors received training in presenting the control group procedures.

Procedures

After screening, signing the informed consent form, and filling out the pretest measures (BDI, Zung Scale, Attribution Scale), the subjects were randomly assigned to either the control group or one of the two treatment conditions. For the paradoxical conditions, treatment consisted of five individual one-hour counseling sessions over a five-week period. Each subject

filled out the BDI and CRF-S after each session. At the end of the fifth session, the subject filled out the posttest Attribution Scale, BDI, and CRF-S. A follow-up session occurred one month after the end of treatment during which the subject filled out all instruments as well as the Feedback Survey and was debriefed. Subjects in the control group treatment met in a group with the counselor. All instruments were administered in the same time sequence and format as for the other two treatments, including follow-up.

Manipulation Checks. The CRF-S was used to demonstrate consistency of counselors' perceived social influence across counselors and across treatment conditions. To assess client perception of treatment condition delivered, clients were asked to fill out the Feedback Survey at follow-up, which assessed how well they had perceived the experimental treatments. This instrument consisted of five statements, one for each of the three treatment conditions, and two dummy items. Subjects were asked to check which statement most closely approximated what their counselor had said to them.

Analysis

A 3 (treatment) x 2 (reactance) x 3 (time) multivariate analysis of variance (MANOVA) was conducted on the BDI and Zung data to test for differences among the treatment conditions and control pseudo-group over the pretest, posttest, and follow-up time periods. Subsequent univariate ANOVAs were run and t-tests performed as follow-ups to significant effects.

To assess changes on the Attribution Scale, data from the scale were subjected to separate MANOVAs to assess for change over time from pretest to posttest and follow-up for items one and six; posttest and follow-up differences were assessed for items two through five.

Results

The manipulation check indicated that 95% of the subjects correctly perceived their treatment condition. Subjects in the reframing condition correctly perceived the appropriate condition 90% of the time; in the restraining condition, 94% of the time; and in the pseudo-control condition, 97% of the time. Both high-reactant and low-reactant subjects correctly perceived the appropriate condition 94% of the time.

A 3 (treatment condition) x 2 (reactance level) x 3 (time) multivariate analysis of variance (MANOVA) was performed on the Beck Depression Inventory and the Zung Self-Rating Depression Scale as dependent measures. There was no significant three-way interaction. There were no significant reactance x time or reactance x treatment condition two-way interactions. There was a significant treatment x time interaction; $F(8,242) = 3.09$, $p < .002$. Follow-up univariate analyses were performed on the BDI and Zung scores separately. To reduce the likelihood of Type I error, the alpha level per comparison was set at $p = .017$. There was a significant treatment x time interaction on the BDI; $F(4,122) = 3.79$, $p < .006$. There was a significant treatment x time interaction on the Zung Scale; $F(4,122) = 5.79$, $p < .0003$. Follow-up univariate tests for each treatment condition were then performed. The BDI showed a significant effect for time for the reframing condition; $F(2,122) = 28.20$, $p < .017$, a significant effect for time for the restraining condition; $F(2,122) = 8.33$, $p < .017$, and a significant effect for time for the pseudo-control condition; $F(2,122) = 5.91$, $p < .017$. The Zung Scale showed a significant effect for time for the pseudo-control condition only; $F(2,122) = 4.44$, $p < .017$.

Follow-up t-tests were used to examine the pattern of change over time for each treatment condition and dependent measure. The significance level of these and subsequent t-tests was set at $p = .01$ to reduce the likelihood of Type I error. Results for the BDI will be presented first. For the reframing condition, there was a significant difference between the pretest and posttest scores; $t = 6.32$, $p < .001$ and between the pretest and follow-up scores; $t = 4.95$, $p < .001$. There was no significant difference between the posttest and follow-up scores. For the restraining condition, there was a significant difference between the pretest and posttest scores; $t = 3.24$, $p < .004$ and between the pretest and follow-up scores; $t = 3.45$, $p < .003$. There was no significant difference between the posttest and follow-up scores. For the pseudo-control group, there was a significant difference between the pretest and follow-up scores; $t = 3.39$, $p < .002$. There were no significant differences between the pretest and posttest scores or between the posttest and follow-up scores. The results for the Zung Scale showed a different pattern. For the pseudo-control condition, there was a significant difference between the pretest and follow-up scores; $t = 3.09$, $p < .005$. There were no significant differences between the pretest and posttest scores or between the posttest and follow-up scores. There were no significant time effects for the reframing or the restraining conditions. In all cases subjects' negative emotions decreased over time. Means and standard deviations are shown in Tables 1 and 2.

A 3 (treatment condition) x 2 (reactance level) x 3 (time) multivariate analysis of variance (MANOVA) was performed on Questions 1 and 6 of the Attribution Scale. These questions were given at pretest, posttest, and follow-up. Question 1 asked, "How much control do you feel you have over your

negative emotions?" Question 6 asked, "How much do you feel you are able to cope with negative emotions?" Each question was answered using a five-point Likert Scale ranging from "not at all" to "completely." There were no significant three- or two-way interactions. There was no significant main effect for reactance level. There was a significant main effect for treatment condition; $F(4,120) = 3.15$, $p < .017$. Follow-up univariate tests showed that there was a significant treatment effect on Question 1 only; $F(2,61) = 5.32$, $p < .007$. A subsequent Tukey test indicated that the restraining group and the pseudo-control group were significantly different, $p < .05$. The pseudo-control group felt significantly more in control than the restraining group. The other groups were not significantly different from each other.

There was a significant main effect for time; $F(4,242) = 4.58$, $p < .001$. Follow-up univariate tests showed that there were significant time effects on Question 1; $F(2,122) = 5.12$, $p < .007$ and Question 6; $F(2,132) = 8.32$, $p < .0004$. Follow-up t-tests on Question 1 indicated that there was a significant difference between the pretest and follow-up scores; $t = 3.10$, $p < .003$. There were no significant differences between the pretest and posttest scores or between the posttest and follow-up scores. Subjects felt that they had more control over their negative emotions at follow-up than at pretest. Follow-up t-tests on Question 6 indicated that there was a significant difference between the pretest and follow-up scores; $t = 3.94$, $p < .001$. There were no significant differences between the pretest and posttest and scores or between the posttest and follow-up scores. Subjects felt that they were better able to cope with their negative emotions at follow-up than at pretest.

A 3 (treatment condition) x 2 (reactance level) x 2 (time) multivariate analysis of variance (MANOVA) was performed on Questions 2, 3, 4, and 5 of the Attribution Scale. These questions were given to the subjects at posttest and follow-up and asked them to think about the changes they had made since the beginning of the study. Questions 2, 4, and 5 measured an external attribution for change, while Question 3 measured an internal attribution for change. Question 2 asked, "Indicate the extent to which those changes were due to the counselor's efforts." Question 3 asked, "Indicate the extent to which those changes were due to your efforts." Question 4 asked, "Indicate the extent to which those changes were due to things that took place in your life over which you had no direct control." Question 5 asked, "Indicate the extent to which those changes were due to efforts of other people (friends, family, etc.) other than you or the counselor." A five-point Likert scale was used, ranging from not at all to completely. There was no significant three-way interaction. There were no significant treatment x reactance level or treatment x time two-way interactions. There was a significant reactance level x time interaction; $F(4,57) = 2.57$, $p < .047$. However, no follow-up univariate tests were significant. Means and standard deviations for all questions are shown in Table 3.

A 3 (treatment condition) x 5 (time) multivariate analysis of variance (MANOVA) was conducted using the three subscales of the Counselor Rating Form-Short (CRF-S) as the dependent measures. The CRF was administered at the end of each of the five sessions. There were no significant three-way or two-way interactions. There were significant main effects for treatment condition; $F(6,132) = 3.90$, $p < .001$ and for time; $F(12,715) = 1.94$, $p < .03$. Follow-up univariate tests on the main effect of time showed that Expertness was

significant; $F(4,272) = 4.89$, $p < .002$. There were no significant differences due to Attractiveness and Trustworthiness. Follow-up t-tests on Expertness showed no significant differences, however. This, it is impossible to trace the pattern of change over time.

A 10 (counselor) x 5 (time) multivariate analysis of variance (MANOVA) was performed on the CRF-S. There was no significant two-way interaction. There was a significant main effect for time; $F(12,641) = 1.92$, $p < .03$. There was a significant main effect for counselor; $F(27,173) = 2.14$, $p < .002$. Follow-up univariate tests showed a significant counselor effect on the Attractiveness subscale only; $F(9,61) = 3.39$, $p < .002$. No further post hoc analyses were conducted due to the small cell sizes.

Discussion

Hypothesis One was partially supported, as demonstrated by the significant treatment condition x time interaction. Although subjects in all three conditions improved significantly, the pattern of change was different between the two paradoxical conditions on one hand and the pseudo-control condition on the other. On the Beck Depression Inventory subjects significantly improved in all three conditions, while on the Zung Scale, they improved significantly in the pseudo-control condition only. In general, subjects in the two paradoxical treatment conditions seemed to improve most between pretest and posttest, rather than between posttest and follow-up. Subjects in the pseudo-control condition did not significantly improve between pretest and follow-up. Perhaps, since the latter subjects received a less active and definitive treatment, they took longer to develop and consolidate their gains. The subjects who received reframing or restraining made whatever

gains they were going to make by the posttest and did not improve significantly thereafter while the pseudo-control subjects made their significant gains after the posttest.

Hypothesis Two was not supported. Reframing was no more effective in reducing depression than restraining. In addition, the pattern of change was the same for both treatments. Significant gains occurred between pretest and posttest, but not between posttest and follow-up. Thus, it appears that the treatments themselves, rather than the passage of time, were responsible for gains made. These results are consistent with the majority of investigations in paradoxical interventions (Dowd & Milne, 1986; Dowd et al., in press) which have failed to find a strong intervention effect for paradox. They are not consistent, however, with the results of studies of the use of paradox in depression (Kraft et al., 1985), which have found reframing to be more efficacious than other interventions.

Hypothesis Three was also not supported, as demonstrated by the lack of significant treatment condition x reactance level or reactance level x time interactions. Subjects who were high reactant were no more likely to improve with a restraining intervention than were low-reactant subjects. Likewise, low-reactant subjects were no more likely to improve with a reframing intervention than were high-reactant subjects. Thus, it appears that neither subject reactance level nor type of paradoxical intervention received was responsible for differential improvement in depression. This is at variance with the few studies done to date (Dowd et al., in press) using psychological reactance which have found that low-reactant subjects improved more on anxiety and procrastination than high-reactant subjects.

Hypothesis Four was generally supported. Although there was initially a significant time effect on the Expertness subscale of the CRF-S, a post hoc analysis failed to detect it. There were no differences on the Attractiveness or Trustworthiness subscales. It could be that counselors in general were perceived over time as more expert, although the nonsignificance of the post hoc test makes that interpretation difficult to validate. There was a significant counselor effect on the CRF-S, but a subsequent analysis determined that this was due to counselor differences on the Attractiveness subscale only. It may be that minor differences in counselor physical attractiveness or attractiveness behavior were responsible for this result. However, this finding may also be an artifact of the small size of some of the cells which precluded further analyses. In any event, differences across counselors do not appear to be substantial.

Hypothesis Five was partially supported. Subjects did indeed feel more in control and better able to cope with their depression at follow-up as compared to pretest. Differential treatment effects appeared on Question 1 only. As hypothesized, there was a significant difference between the restraining condition and the pseudo-control condition, but not between the reframing and restraining conditions in perceived control. But, the directionality of effects was reversed. Subjects in the pseudo-control condition felt more in control at follow-up than those in either of the two paradoxical conditions. These results are somewhat inexplicable. However, the subjects in the pseudo-control condition received highly structured information that may have fostered a sense of learning and control.

Hypothesis Six was not supported. There were no differences between high-reactant and low-reactant subjects in their feelings of control and

coping ability regardless of treatment condition. Thus, the compliance-defiance model, which predicts that paradoxical interventions will be differentially effective with clients of different reactance levels, was not supported.

Hypothesis Seven was likewise not supported. Although there was a significant reactance x time interaction, subsequent tests failed to detect it. Hypothesis Eight was not supported. Contrary to research in attribution (Kopel & Arkowitz, 197?), restraining strategies, which are ambiguous in nature, failed to result in internal attributions for change to a greater extent than reframing interventions.

The results, while not as definitive as expected, are somewhat congruent with past research. All three treatment conditions resulted in significant decreases in depression scores, at least as measured by the BDI. This is similar to past research which has shown that depression can be alleviated by a wide variety of interventions. Although there were no significant differences among the treatment conditions, an inspection of the means in Tables 1 and 2 show that the changes were in the hypothesized direction. Both the reframing and restraining conditions resulted in rapid decreases in depression from pretest to posttest, with the reframing condition showing the greatest decrease. The pseudo-control condition resulted in only a modest decrease, however. Furthermore, the major gains for both paradoxical conditions were made during the treatment phase, while the gains for the pseudo-control condition were considerably slower in occurring. Thus, it appears that reframing and restraining strategies may be more powerful than simply providing information about depression, and that reframing may be a

more powerful technique than restraining. Differences between these results and those obtained by Kraft et al. (1985) may be due to differences in level of depression of the subjects. The latter study used mildly depressed college students, while the present study used a moderately to severely depressed clinical population. Perhaps reframing works best with mild to moderate depression only. Future research might profitably compare the effect of paradoxical interventions with clients at different levels of depression. In addition, Kraft et al. (1985) used only one initial measure of depression, while this study used two different measures at two different points in time. Depue and Monroe (1978) and Kendall, Hollon, Beck, Hammer, and Ingram (1987) discuss the necessity of assessing initial level of depression using multiple measures in order to insure the stability of the depression.

These results are also congruent with the majority of studies on the efficacy of paradoxical interventions (Dowd & Milne, 1986). These studies have shown that, while paradoxical strategies are effective in alleviating the wide variety of psychological disturbances, they are no more effective than nonparadoxical strategies. Furthermore, there has not been convincing evidence that different types of paradoxical interventions are differentially effective (Dowd et al., in press). Subjects also felt more in control of and able to cope with their depression as a result of the treatment conditions, although again there were no differential treatment effects, further buttressing these conclusions.

More disappointing was the failure to find significant effects due to client reactance level. Initial results of this line of investigation have been highly promising (Dowd et al., in press), in that it appeared that reactance level might be an important variable mediating client outcome. The

general outcome literature in psychotherapy has found that client variables may be responsible for the greatest variance in client outcome, followed in that order by therapist variables and technique variables (Bergin & Lambert, 1978). The differences in results may be due to two factors. This study used depression as the client problem, while Dowd et al. used anxiety and procrastination. In addition, this study used a severely disturbed client population, while Dowd et al. used a mildly distressed college student population. It may be that reactance level is a more significant client variable in mild degrees of disturbance and may be overridden by other factors in more severely disturbed populations. There may be a biological component in severe depression which might overwhelm such psychological characteristics as reactance. It should be noted that the majority of subjects in this study were severely enough depressed to require medication. Further research is necessary to refine the conditions under which psychological reactance is a significant variable in client outcome.

There were no differences in external or internal attributions for change due to either client reactance level or treatment condition. However, it should be noted that attributions were measured by a four-item scale of unknown reliability and validity. Thus, the lack of significant results may be due to scale deficiencies rather than inadequate theory. It might be useful to develop a measure of specific attributions for change and use this in future research on this topic. The compliance-defiance model, as well as substantial clinical lore, suggests that if clients are unable to pinpoint a specific external cause of change, they will tend to attribute change to their own actions. Hypotheses derived from this model have not been sufficiently

tested.

We would encourage others to conduct research on actual clinical populations, rather than relying on the ubiquitous and long-suffering college student. While researchers can be forgiven for using the most available and controllable subject population, more information can be obtained using "real" clients or patients. The results are well worth the effort!

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Table 1

Mean Beck Depression Scores

Condition	n	Beck Depression Inventory		
		Pretest	Posttest	Follow-up
Reframing	21			
M		33.32	12.23	14.67
SD		17.51	8.78	13.57
Restraining	18			
M		28.29	19.90	18.67
SD		17.27	15.40	11.00
Control	28			
M		22.89	17.25	14.57
SD		13.79	12.52	9.95

Note: Possible range for scale is 0 to 63. Normal range = 0 to 9, mild depression = 10 to 15, mild-moderate depression = 16 to 19, moderate to severe depression = 20 to 29, severe depression = 30 to 63.

Table 2

Mean Zung Self-Rating Depression Scores

Condition	n	Zung Self-Rating Depression Scale		
		Pretest	Posttest	Follow-up
Reframing	21			
M		57.27	46.64	42.95
SD		7.69	10.58	10.42
Restraining	18			
M		52.43	50.80	49.72
SD		11.26	11.85	10.91
Control	28			
M		48.71	47.64	43.89
SD		10.91	9.88	11.51

Note: Possible range for scale is 20 to 80. Normal range = 0 to 40, mile to moderate depression = 40 to 47, moderate to severe depression = 48 to 55, severe depression = 56 to 80.

Table 3

Mean Attribution Scale Scores

Condition	Attribution Scale Scores		
	Pretest[a]	Posttest	Follow-up
1-Control			
M	2.31	2.54	2.75
SD	1.03	1.05	.99
6-Coping			
M	2.36	2.67	3.00
SD	1.11	1.06	1.14
2			
M	--	3.05	3.05
SD		1.16	.99
3			
M	--	3.18	3.39
SD		1.02	.97
4			
M	--	3.15	3.00
SD		1.07	1.14
5			
M	--	2.88	3.18
SD		1.12	.89

[a] Pretest scores not obtained Questions 2, 3, 4, 5.

Note: Scale Range is from 1 (not at all) to 5 (completely), Likert scale.